STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676465	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Alturas Nursing & Transitional Care	4301 North Bartlett Avenue Laredo, TX 78041

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation were reported immediately, but not later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials, including to the State Agency, in accordance with State Law through established procedures for 1 out of 5 residents (Resident #1) reviewed for reporting of abuse/neglect. The facility failed to report an allegation of abuse of Resident #1 within 2 hours that occurred on 11/14/25 at around 4:00 PM. This failure could place residents at risk for potential abuse. The findings included:Record Review of Resident #1's face sheet dated 12/29/25 revealed a [AGE] year-old female with an admission date of 11/08/22. Resident #1's pertinent diagnoses included cerebral infarction (blocked artery cuts off blood flow to part of the brain, causing brain cells to die from lack of oxygen and nutrients). Record review of Resident #1's Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 3 which indicated her cognition was severely impaired. Further review of the MDS revealed Resident #1 had no physical behavioral symptoms such as hitting, kicking, or pushing in the week leading up to the assessment. Record review of Resident #1's comprehensive care plan dated 12/29/25 revealed the focus I have a tendency to have combative behaviors and I may become physically aggressive towards staff when care is provided, I hit and bite initiated on 12/26/23 and revised on 11/18/25. Record review of the provider investigation revealed the following summary: On November 17, 2025, at approximately 5:00 PM, [NAIT A] notified nurse in charge that on Friday, November 14, 2025 during his shift, he could not recall time, he observed [CNA B] hit [Resident #1] on the arm while they were providing care to her. In an interview with CNA B at 3:04 PM on 12/29/25, CNA B stated on November 14th, 2025, she asked CNA C for assistance in bathing Resident #1 sometime in the afternoon. CNA B stated Resident #1 required two CNAs to transfer her from her bed to the shower chair. CNA B stated Resident #1 had a history of being combative when trying to bathe her. CNA B stated while her and CNA C were transferring Resident #1 to the shower chair, Resident #1 hit CNA C on her arm. CNA B stated CNA C had raised her own arm to protect herself from Resident #1's strikes, but at no point throughout the transfer did CNA C hit Resident #1. In an interview with CNA C at 3:28 PM on 12/29/25, CNA C stated CNA B asked her for assistance in helping shower Resident #1. CNA C stated Resident #1 had a history of getting aggressive with staff when they tried to bathe her. CNA C stated she never hit Resident #1 during the transfer, but that Resident #1 did hit her on her arm. CNA C stated once they got Resident #1 into the shower chair they were able to bathe her without any further incident. In an interview with Resident #1 at 3:50 PM on 12/29/25, Resident #1 stated she had never been physically abused by a staff member. Resident #1 stated that she did get aggressive with staff members sometimes when they tried to bathe her because the water was cold sometimes. In an interview with NAIT A at 4:55 PM on 12/29/25, NAIT A stated he was training with CNA B and CNA C on 11/14/25, the day of the alleged abuse incident. NAIT A stated Resident #1 was visibly uncomfortable and crying during her transfer. NAIT A stated Resident #1 insulted CNA C calling her a daughter of a bitch mother. NAIT A stated Resident #1 hit CNA C on the arm, and then CNA C hit Resident #1 back on her left arm in retaliation. NAIT A stated he thought he witnessed physical and mental abuse. NAIT A stated he did not report it immediately because he froze in the moment and did not know what to do. NAIT A stated he did not tell anyone about the incident until 11/17/25, 3 days later when he told his charge nurse. NAIT A stated he had been trained in school to report abuse immediately to keep residents safe. In an interview with LVN D at 5:30 PM on 12/29/25, LVN D stated she was the charge nurse for Resident #1 on 11/17/25. LVN D stated she could not remember who said it, but someone from administration told her to perform a head-to-toe skin assessment on Resident #1 on 11/17/25. LVN D stated she performed the head-to-toe skin assessment and the findings showed no abnormalities. In an interview with the DON at 5:41 PM on 12/29/25, the DON stated anytime a staff member witnessed something they thought might be abuse that should remove the resident from the situation and inform the administrator immediately. The DON stated the facility had 2 hours to report any allegations of abuse to all appropriate parties. The DON stated it was important to report all allegations immediately to keep residents safe and initiate the investigation as soon as possible. The DON stated she did not know why NAIT A waited 3 days to report his allegation of abuse to the administration. The DON stated all NAIT's were trained at orientation to report any possible abuse immediately to the administrator. In an interview with the ADM at